

Provider Child Care Central Database Application

PROVIDER INFORMATION

_____ RENEWAL

Check if new address or phone number _____

Name _____ Social Security Number _____

Street Address _____

City _____ State _____ Zip Code _____

Phone # _____ Alternate Phone # _____ Fax # _____

e-mail Address: : _____ Website Address: _____

Which category of regulation applies to your family child care home?

____ County Permit ____ Fairfax City ____ Ft. Belvoir ____ State License (Dates) from _____ to _____
____ Falls Church City ____ Infant/Toddler Family Child Care System

Accreditations

____ NAFCC _____ CDA _____ Expiration Date _____
National Association of Family Child Care Child Development Associate Credential

Do you have Pets? ____ Yes ____ No If yes, ____ Indoors ____ Outdoors only

Do you provide a smoke free (no one in the home is a smoker) environment? ____ Yes ____ No

Is your home: ____ Near public transportation ? ____ Wheelchair accessible ?

USDA Food Program Participation

____ OFC USDA Food Program ____ Other USDA Food Program _____ none

List your neighborhood elementary school

School Name (base school) _____

REGISTRATION FEE \$ _____ ____ One-time ____ Yearly

FEES

Check all ages you serve:

____ Infants (birth - 15 months) \$ _____
____ Toddler (16 - 23 months) \$ _____
____ Two-year old (24 – 35 months) \$ _____
____ Young Preschool (36 – 47 months) \$ _____
____ Older Preschool (48 – 59 months) \$ _____

Weekly Child Care Rates:

____ Kindergarten (60 – 71 months) \$ _____ full day
____ before and after kindergarten \$ _____
____ School age (72 months – 13 years) \$ _____ full day
____ before and after school \$ _____

Care Level**Schedule** Hours and days of operation as well as alternative schedules you offer**Hours of Operation:** Open _____ a.m. Close _____ p.m.

Minimum age you would enroll _____ mos/ys Maximum age you would enroll _____ mos/ys

Schedule Options: ☐ Full-time only ☐ Full-time and Part-time ☐ Part-time only**Days of Operation:** ☐ Sun ☐ Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat**Alternative Options you are willing to consider:**

<input type="checkbox"/> before school	<input type="checkbox"/> weekend care	<input type="checkbox"/> shift/rotating week
<input type="checkbox"/> after school	<input type="checkbox"/> holidays/vacation	<input type="checkbox"/> summer only
<input type="checkbox"/> before/after preschool	<input type="checkbox"/> occasional/back-up	<input type="checkbox"/> school year only
<input type="checkbox"/> extended hours	<input type="checkbox"/> mornings	<input type="checkbox"/> year round
<input type="checkbox"/> evening care		

Describe any other schedule options you offer: _____

SPECIAL SERVICES**Experience or training in the care of children with special needs** ☐ Yes ☐ No**Check if you have experience or training to provide the following types of special care:**

<input type="checkbox"/> Adaptive/special equipment (apnea monitor, catheter, g-tube, nebulizer)	<input type="checkbox"/> Downs Syndrome
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emotional/learning disabilities (ADHD/ADD, autism, challenging, behaviors)
<input type="checkbox"/> Asthma/respiratory conditions	<input type="checkbox"/> Physical Impairments (hearing impaired, motor impairment, visually impaired)
<input type="checkbox"/> Cerebral Palsy, neurological or seizure disorder	<input type="checkbox"/> Physical or occupational therapy
<input type="checkbox"/> Development delay (language/speech delay)	<input type="checkbox"/> Special diets
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Dispense Medication	

Are you willing to provide care for mildly ill children? (colds, ear infection, fever, etc.) ☐ Yes ☐ No**Language: Please list the languages you speak:** ☐ English ☐ Spanish ☐ Vietnamese
☐ Farsi ☐ Korean ☐ Hindi ☐ Punjabi Other (please specify) _____**Can you use sign language?** ☐ Yes ☐ No**Do you transport children ?:**

Other School _____ To School _____ From School _____

☐ from their home to your care? ☐ Yes ☐ No

☐ from your care to their home? ☐ Yes ☐ No

Signature _____**Date** _____

By signing this application to become part of the Child Care Central Database, I understand that information about my program will be made available to the public through the Office for Children's Child Care Central Website and on listings requested by parents. I also understand that the Office for Children reserves the right to remove a child care program from the Child Care Central Database.

Please call Community Education and Provider Services at (703) 324-8100 with any questions.

www.fairfaxcounty.gov/childcare**FAIRFAX COUNTY OFFICE FOR CHILDREN**12011 Government Center Parkway, 8th Floor Suite 820

Fairfax, VA 22035-1104

Fax: (703) 324-3925

For Office Use Only

CCMS # _____

Map Code _____

Application Received _____

Date entered into CCMS _____